PRINTED: 06/19/2018
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018	A. BUILDING: _____ B. WING _____	C 06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VILLAGE COMMUNITY CARE HOME	99 ATKINSON STREET BELLOWS FALLS, VT 05101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted in conjunction with an entity reported incident investigation on 6/12/18 by the Division of Licensing and Protection. There were regulatory findings.	R100		
R121 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.g A licensee who intends to discontinue all or part of the operation, or to change the admission or retention policy, ownership, or location of the home in such a way as to necessitate the discharge or transfer of residents shall notify the licensing agency and residents at least ninety (90) days prior to the proposed date of change. The licensee is responsible for ensuring that all residents are discharged or transferred in a safe and orderly manner. When such change in status does not necessitate the discharge or transfer of residents, the licensee shall give the licensing agency and residents at least thirty (30) days prior written notice. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to give written notice regarding the closure of the home and the need to discharge to another location for 7 of 10 residents, Resident #3, 4, 5, 6, 7, 8 and 9. Findings include: Per record review of the above mentioned residents, there was no evidence of written notification provided regarding the closure of the home nor discharge from the facility. During an	R121		

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R121	Continued From page 1 interview with the owner/manager of the home on 6/12/18 at 10:00 AM, s/he confirmed that the facility would be closing as of July 1, 2018 and s/he made a verbal announcement to all the residents in April that the home would be closing but s/he had not provided the above mentioned residents with written notification.	R121		
R161 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that all medications were handled according to the policies and procedures for 2 residents reviewed, Resident #1 and 2. Findings include: 1.) On 3/15/18 the medication delegated staff member on the night shift took 4 (four) Tramadol 50 mg (milligram) tablets for Resident #1. The staff member crushed these pills and placed them in medication cups in the top drawer of the medication cart. Per interview with the Registered Nurse (RN) on 6/12/18 at 9:45 AM, a complete investigation of the error was done and the staff said that this was done in anticipation of Resident #1 requesting the Tramadol during the night as they often do. The resident instead requested Tylenol 325 mg 2 (two) tablets, which	R161		

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R161	Continued From page 2	R161		

s/he received. The crushed medication was found in the medication drawer the next morning by the day shift. The RN stated that it is not the policy of the facility to pre-pour and leave medications that are not given. The owner of the home confirmed at 9:45 AM that the policy and procedure for medication administration was not followed.

2.) On 3/27/18, Resident #2 requested Tylenol 325 mg two tablets and was administered Tramadol 50 mg two tablets instead. The RN stated that the resident has orders for Tramadol and Tylenol as prn (as needed) medications. During the facility investigation of the medication error, the medication staff member did not follow the policy and procedure for checking the medications administered with the written orders, the Medication Administration Record and the label. The owner confirmed at 9:45 AM on 6/12/18, that the policy for medication administration was not followed.